



CB-LIGHT-10

EXHIBIT W

UNITED STATES DISTRICT COURT

DISTRICT OF NEW JERSEY
10-3950DRD

DISABILITY RIGHTS NEW JERSEY, INC.,
et al.,

Plaintiffs,

vs.

JENNIFER VELEZ, in her official capacity as
Commissioner of the New Jersey Department
of Human Services, et al.,

Defendants.

DEPOSITION OF:
KIM EVANS-MALLORY

Tuesday, March 20, 2012

Reported By:

LISA FORLANO, CCR, CRR, RMR

REF: 7004

COPY

1 KIM EVANS-MALLORY

2 What degree did you receive from
3 Fairleigh Dickinson?

4 A A degree in sociology.

5 Q And in what year?

6 A 1979.

7 Q Other than FDU, do you have any other
8 post-high school education?

9 A No.

10 Q Any other professionals -- do you have
11 any professional certifications aside from your FDU
12 degree?

13 A No.

14 Q After -- after you graduated Fairleigh
15 Dickinson, did you begin working immediately after?

16 A Yes, I did.

17 Q Where did you work?

18 A At the Arthur Brisbane Child Treatment
19 Center in Wall Township, New Jersey.

20 Q Okay. And when did you finish working
21 at the Arthur Brisbane Center?

22 A December 2005.

23 Q And after you ended work there, did you
24 work elsewhere?

25 A Trenton Psychiatric Hospital in

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2 Trenton, New Jersey.

3 Q Okay. Is that when you began as a

4 Client Service Representative --

5 A No.

6 Q -- or is that in a different capacity?

7 A No. I had been a Client Service

8 Representative at Arthur Brisbane Child Treatment

9 Center. I was transferred to Trenton Psychiatric

10 when the hospital, Arthur Brisbane closed.

11 Q Okay. So when you began at Trenton

12 Psychiatric, what position did you hold?

13 A Still the Civil Service title of Client

14 Service Representative, RENNIE advocate.

15 Q And when you were in Arthur Brisbane,

16 you were just the Client Services Representative?

17 A No, prior to that I was the Program

18 Development Specialist.

19 Q Okay. And what were your

20 responsibilities at the Arthur Brisbane Center?

21 A In -- at both job titles?

22 Q I guess start with the first job title

23 you had after graduating.

24 A The first job title I helped discharge

25 planning for the clients.

1 KIM EVANS-MALLORY

2 Q Oh. Is there any way in which it's not
3 a description?

4 A No. No.

5 Q Okay. Have you ever made a
6 recommendation for changes to involuntary medication
7 process?

8 A Yes. Yes.

9 Q And when was this?

10 A During one of our RENNIE meetings. I
11 don't -- I can't give you the exact date. We've
12 always discussed different things, policies and
13 procedures in our meetings.

14 Q Okay. So when you've made
15 recommendations for changes to the involuntary
16 medication process, did you make only one
17 recommendation or more than one?

18 A We've made many over the years. It's
19 difficult to pinpoint.

20 Q Sure. And when you say "we," who
21 exactly are you talking about?

22 A The group of RENNIE advocates as a
23 whole.

24 Q Okay. So when was the most recent
25 instance in which you or other RENNIE advocates --

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2 sorry, strike that.

3 When is the most recent instance in
4 which you have made a recommendation for a change in
5 the involuntary medication process?

6 A When we were discussing doctors'
7 monthly progress notes.

8 Q And do you recall when that happened?

9 A No, I don't. Like I said, we meet
10 monthly, so it's very difficult to pinpoint.

11 Q Sure.

12 A I mean, I've been going to these
13 meetings for almost 20 years.

14 Q I understand that. Do you have an idea
15 of what year it was in?

16 A Maybe two years ago, approximately,
17 maybe. I'm not positive.

18 Q Okay. And you said the topic of that
19 meeting in which you made that -- the most recent
20 recommendation, the topic was monthly progress
21 notes?

22 A Yes.

23 Q Was the recommendation for a change
24 that you made at that time, was that related to the
25 monthly progress notes?

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2 A It was -- we discussed it at our
3 meeting and Karen Piren who works -- who was our
4 liaison to central office brought it to the
5 attention of central office.

6 Q What exactly did she bring to the
7 attention of the central office?

8 A That we felt that maybe the doctors
9 needed some type of a form where it would be unified
10 throughout the hospitals on how they did their
11 monthly progress notes.

12 Q Okay. So you recommended -- I'm trying
13 to understand this. You recommended a separate form
14 that was related to the monthly progress note that
15 would be in addition to the monthly progress notes?

16 A No. We recommended some type of a form
17 that could be used that would be generic to all the
18 hospitals.

19 Q Okay. So taking a step back,
20 psychiatrists in the hospitals fill out monthly
21 progress notes?

22 A Yes.

23 Q And they're required to fill these out?

24 A Yes.

25 Q And when you recommended a change

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2 Q Okay.

3 A So this would help alleviate that
4 problem with all the other documentations that
5 they're doing in the chart.

6 Q Okay.

7 MR. LEYHANE: It's like EZ Pass. Okay?

8 BY MR. SEBROW:

9 Q Do you keep copies of these -- of
10 the -- well, let me step back.

11 Was this recommendation ever
12 implemented?

13 A Yes.

14 Q Okay. And so that form that we were
15 just discussing that's in addition to the monthly
16 progress note --

17 A It's not in addition to, it is the
18 monthly progress note.

19 Q It is the monthly progress note?

20 A Yes.

21 Q Okay. So the monthly progress note was
22 changed somewhat in response to the recommendation?

23 A Somewhat, yes.

24 Q To the recommendation that you made?

25 A Yes.

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2 Q Okay. And when you bring it to their
3 attention, are you -- are you saying that -- do
4 you -- strike that.

5 When you bring these issues to the
6 treating psychiatrist or the treatment team, do you
7 just tell them the facts that this patient is
8 refusing or do you advocate for the patient's
9 wishes, for example, by saying I want, you know, I
10 think the patient is right, for example? I think
11 the patient should not have to take their
12 medication?

13 A No. I bring the patient's -- what they
14 have told me to the treatment team. It is up to the
15 treatment team and the treating physician to
16 determine what is best for the patient at that time.

17 Q Okay. So you don't try to convince the
18 treating team or the treating psychiatrist to take
19 one action or another?

20 A No.

21 Q Is that because you don't feel
22 qualified to do that or is it because you don't
23 think it's part of your job or both?

24 A I'm not qualified to do that because
25 I'm not a clinician or a physician. I am qualified

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2 as an advocate to speak on behalf of my patient to
3 the treatment team and hope that they can come to a
4 happy medium.

5 Q Okay. Do you try to convince the
6 treatment team to come to a happy medium?

7 A I'm not there to convince the treatment
8 team. I'm just there to bring the patient's wishes
9 and desires known to the team.

10 Q So if a patient expresses his or her
11 desires to you and then you bring that to the
12 treatment team and then let's say the treating
13 psychiatrist says, I disagree, I'm going to take
14 action contrary to the patient's wishes, at that
15 point do you try to change the treating
16 psychiatrist's mind?

17 A No.

18 MR. SEBROW: I think we can take a
19 break at this point.

20 MR. LEYHANE: Okay.

21 VIDEO OPERATOR: The time is 11:14 a.m.
22 and we are off the record.

23 (Brief recess.)

24 VIDEO OPERATOR: The time is 11:39 a.m.
25 and we are back on the record.

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2 Psychiatry. And his decision would be final.

3 Q Okay. So with the grievance, the first
4 step is for the patient to fill out a form?

5 A Yes.

6 Q Are you involved in that step?

7 A No, not necessarily. Unless the
8 patient requested my assistance.

9 Q Okay. And then the form gets sent to
10 the treatment team?

11 A The form would be given to the
12 treatment team, yes.

13 Q How does the patient send the form to
14 the treatment team?

15 A They would give it to the program
16 coordinator or their social worker on their team.

17 Q Okay. And how would a patient know how
18 to fill out that form?

19 A They're informed on admission.

20 Q Is there any other information that
21 they're given at any time about the forms?

22 A They get a patient orientation
23 handbook. They have an orientation class and by
24 posting on the walls, on the bulletin boards at the
25 hospital.

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2 A Yes, I do.

3 Q And can you tell me what it is, please?

4 A Yes, it's the revised AB:504.

5 Q And when you say it's revised, it was
6 revised on September 1, 2011; is that your
7 understanding?

8 A Yes, it is.

9 Q And do you know what the revisions
10 involved?

11 A The revisions were in reference to the
12 administration of emergency medication on a 72-hour
13 basis.

14 Q Okay. But the revisions did not change
15 any procedure regarding the administration of
16 psychotropic drugs involuntarily to patients, right?

17 A To my knowledge, that is correct.

18 Q So this is the most current version of
19 the three-step process?

20 A Yes, it is.

21 Q And can you just go over with me,
22 please, what the role of the RENNIE advocate is in
23 the three-step process?

24 A The role of the RENNIE advocate in the
25 three-step process is to meet with the patients

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2 prior to the team meeting to discuss and make the
3 patients aware of what their rights are in regards
4 to involuntary medication.

5 Q Okay. So you make the patient aware of
6 what their rights are?

7 A Yes.

8 Q And you attend a treatment team
9 meeting?

10 A If the patient requests my attendance,
11 yes.

12 Q Is there any other way that you're
13 involved in the three-step process?

14 A No.

15 Q Okay. And how do you make a patient
16 aware of what his or her rights are?

17 A By explaining to them that they have a
18 right to be free from excessive medication and that
19 they also can be medicated against their will if the
20 treating physician feels it is necessary.

21 Q Is that the only way you make a patient
22 aware of what their rights are?

23 A No. They have the Bill of Rights, as
24 well.

25 Q Do you read them the Bill of Rights?

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2 A On occasion.

3 Q Do they have copies of the Bill of
4 Rights?

5 A I believe they do. There's copies on
6 all of our units and they sign for the Bill of
7 Rights on admission.

8 Q Besides making the patients aware of
9 what their rights are and attending a treatment team
10 meeting --

11 A If requested.

12 Q If requested, there are no other ways
13 that you're involved in the RENNIE process?

14 A No.

15 Q So it's not your job to make sure that
16 the three-step process is completed satisfactorily?

17 A At the end, yes, it is.

18 Q So part of your responsibilities
19 relating to the RENNIE process as described in
20 AB:504 is making sure that the process is completed
21 appropriately?

22 A I review to make sure that the process
23 has been completed.

24 Q Do you make sure the forms are
25 completed properly?

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2 A I make sure that the form is complete
3 and if it's done properly, then I will inform the
4 treating physician, the team and the Chief of
5 Psychiatry.

6 Q Okay. So besides making a patient
7 aware of what their rights are, --

8 A Uh-huh.

9 Q And attending a treatment team meeting,
10 if requested.

11 A Yes.

12 Q And making sure that the process is
13 completed properly, which includes making sure --

14 A I review the process to see that it was
15 completed.

16 Q Sorry. And reviewing the process to
17 make sure it is completed properly.

18 A I review to make sure the process was
19 completed. If it was not done properly, then I
20 would bring it to the necessary -- attention to the
21 necessary people.

22 Q Okay. So besides for those three
23 issues, are there any other ways that you're
24 involved in the RENNIE process?

25 A I do a monthly review once the process

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2 MR. SEBROW: That's why I asked it.

3 MR. LEYHANE: Do you want to listen to
4 your question? Or do you want to explain what
5 the problem is? Melody says, no. Sorry.

6 MS. WELLS: I didn't say anything.

7 BY MR. SEBROW:

8 Q Have you received any complaints from
9 patients that they have not been made aware of the
10 existence or the assistance of a RENNIE advocate?

11 A No, I have not.

12 Q Do you know of -- you have no knowledge
13 of any complaints like that?

14 A Do I have knowledge of complaints like
15 that or have I been made aware of complaints or --
16 because you --

17 Q Sure. Sorry. Let me rephrase it.

18 A Okay.

19 Q Do you have any knowledge of complaints
20 made by patients that they were not advised of the
21 potential assistance of a RENNIE advocate?

22 A Yes.

23 Q Can you describe for me each instance
24 that you know of?

25 A Excuse me, if I'm not mistaken, your

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2 Q How often was that the case?

3 A I would say the majority of the time.

4 Q Okay. And in those cases, is it your
5 understanding that the patient could have been
6 forcibly medicated under the three-step process
7 before you ended up receiving these forms?

8 A Yes.

9 Q Okay. And once you received those
10 forms, what did you do?

11 A I did a medication review form -- a
12 review. I did a chart review.

13 Q And what did this review consist of?

14 A It consisted of reviewing the chart,
15 looking at the doctor's notes, observing the
16 patient.

17 Q When you say "observing the patient,"
18 what do you mean by that?

19 A Just looking at the patient to see if
20 there were any, I guess, EPS symptoms,
21 extrapyramidal symptoms.

22 Q Okay. Can you describe what are
23 "extrapyramidal symptoms"?

24 A Maybe drooling, drowsiness.

25 Q Anything else that you would observe

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2 become a voluntary patient and he wants to go to
3 court. But other than that, to my knowledge, no.

4 Q And in that instance that you just
5 mentioned, was that -- did that involve a treatment
6 decision pursuant to the three-step process or was
7 it something different?

8 A I believe it was something different.

9 Q Okay. Have patients ever asked for
10 attorneys to help them with issues relating to the
11 three-step process?

12 A No.

13 Q Do you know whether patients have
14 access to attorneys?

15 A Yes.

16 Q And how do they have access to
17 attorneys?

18 A Through the Public Defender, which
19 represents them in court. They can seek the help of
20 the NJR, which provides attorneys or they can hire
21 their own private attorney.

22 Q Okay. Does the hospital help them get
23 an attorney, if they want?

24 A Their social worker can guide them in
25 that direction.

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2 that meeting, of the proposed policy, have you told
3 me everything that you can recall that was
4 discussed?

5 A Yes. Yes, I have.

6 Q Is it your understanding that patients
7 refusing medication currently do not have a right to
8 an independent judicial hearing before they're
9 involuntarily medicated?

10 A Yes.

11 Q And has any patient ever requested
12 this?

13 A No.

14 Q Do you think that an independent
15 judicial hearing would improve the process for
16 patients?

17 A No, I do not.

18 Q And why not?

19 A Right now the patients have three
20 opportunities to voice their opinion before they're
21 medicated. At the very first step, or when the
22 doctor discusses medication and possibly putting
23 them on involuntary medication, again, at the
24 treatment team meeting level, and then when they
25 meet with the Medical Director before he signs off

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2 on it. It also would hold up medicating a patient
3 if they have to wait to go before a judge, which
4 could tie up their discharge or their -- if
5 medication is what they need to stabilize them and
6 to get them discharged quicker, and it would also,
7 on the opposite end, increase our population.

8 Q How would it increase your population?

9 A Because if it's going to take longer to
10 see the judge before a patient can get medicated and
11 stabilized and get discharged and we continue to get
12 admissions.

13 Q Okay. Do you know how long it would
14 take for a judicial process to take place?

15 A No, I do not.

16 Q So when you say that you think that it
17 would take a long time, what's your basis for saying
18 that?

19 A That's just -- I know courts do not
20 convene -- I mean, they may convene frequently, but
21 not necessarily for your case.

22 Q Are there any judicial -- are there any
23 judicial hearings that take place in Trenton
24 Psychiatric Hospital for any reason?

25 A Yes, there is.

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2 judicial hearing for involuntary medication would
3 take?

4 MR. LEYHANE: Objection.

5 THE WITNESS: It would not.

6 BY MR. SEBROW:

7 Q You also mentioned that one concern
8 about judicial hearings was that it would lead to
9 patients not being discharged?

10 A Possibly, yes.

11 Q Okay. Do you have any basis for that
12 opinion?

13 A If a doctor is putting a patient on
14 involuntary medication because he or she feels they
15 needed to help stabilize their -- or clear up their
16 clinical picture at this time, then how can we
17 discharge someone that's not stable back into the
18 community?

19 Q Okay. But you understand that an
20 independent judicial hearing wouldn't involve
21 discharging the patient, it would only involve
22 bringing them before a judge?

23 A But if you have to wait a period of
24 time to get that hearing scheduled and set or take
25 the patient to the court hearing, it could be a

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2 independent judicial hearing for involuntary
3 medication purposes, that those hearings in other
4 states took place very quickly, would that change
5 your opinion about whether independent judicial
6 hearings would be a problem for -- in New Jersey?

7 A No, it would not.

8 Q Okay. If a patient is refusing to take
9 medication -- non-psychotropic medication such as
10 antibiotics --

11 A Yes.

12 Q -- can that patient be three-stepped?

13 A No.

14 Q That patient has a right to refuse that
15 medication?

16 A I believe they do, yes.

17 Q And they can't be forced to take that
18 medication?

19 A No.

20 Q And is it your experience that no one
21 has forced patients to take medications like that?

22 A Medical medications?

23 Q Yes.

24 A To my knowledge. Unless there's a
25 guardian in place or it's a matter of life and death

EXHIBIT X

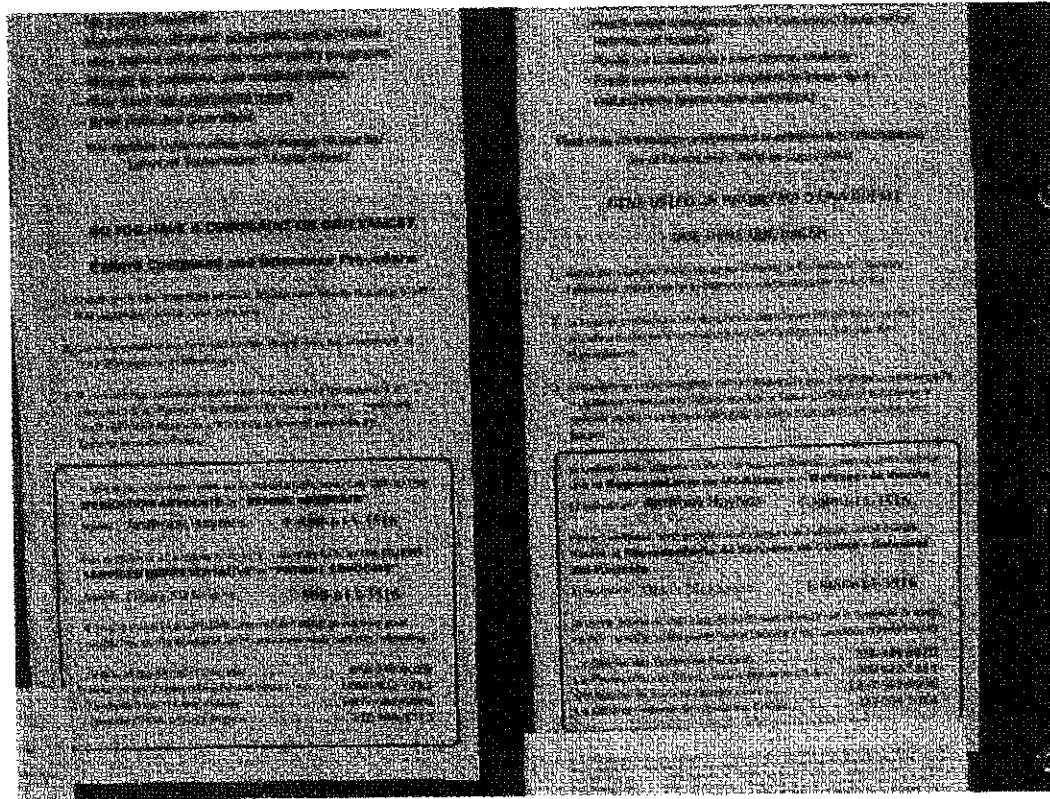


Figure 1

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DO NOT HAVE A COMPELLING OR OTHER INTEREST

Abstract

As a result, the authors conclude that the use of the *in vitro* model is not appropriate for the study of the effects of the chemical on the *in vivo* system.

[illegible]

As the public and institutional sectors are charged with the responsibility of providing a high-quality education to every child, they must ensure that all children have the opportunity to learn and that the quality of the learning environment is high.

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1000 GILBERT

FOR INFORMATION OF THE FBI, THE FOLLOWING INFORMATION WAS OBTAINED FROM THE RECORDS OF THE FBI, THE DEPARTMENT OF JUSTICE, AND THE DEPARTMENT OF THE ARMY:

2000-01-17 14:16

[illegible][illegible]

1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

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Abstract—The purpose of this study was to determine if there were differences in the prevalence of musculoskeletal disorders between two groups of nurses working in different departments of a hospital. The sample consisted of 100 nurses from the Intensive Care Unit (ICU) and 100 nurses from the General Ward. Data were collected by means of a self-administered questionnaire. The results showed that the prevalence of musculoskeletal disorders was higher among ICU nurses than among General Ward nurses. The most common disorder was low back pain, followed by neck pain and shoulder pain. The findings suggest that interventions aimed at reducing the risk of musculoskeletal disorders should be targeted towards ICU nurses.

part of the program. This is a very important part of the program.

NOTES ON THE PROBLEM OF THE

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Abstract. The purpose of this study was to determine if there were differences in the prevalence of dental caries between children who had been exposed to fluoride varnish and those who had not. A total of 600 children aged 5-7 years were examined by dentists at a community health center. The results showed that the prevalence of dental caries was significantly lower in the group that had received fluoride varnish than in the control group. This suggests that fluoride varnish may be an effective method for preventing dental caries in children.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

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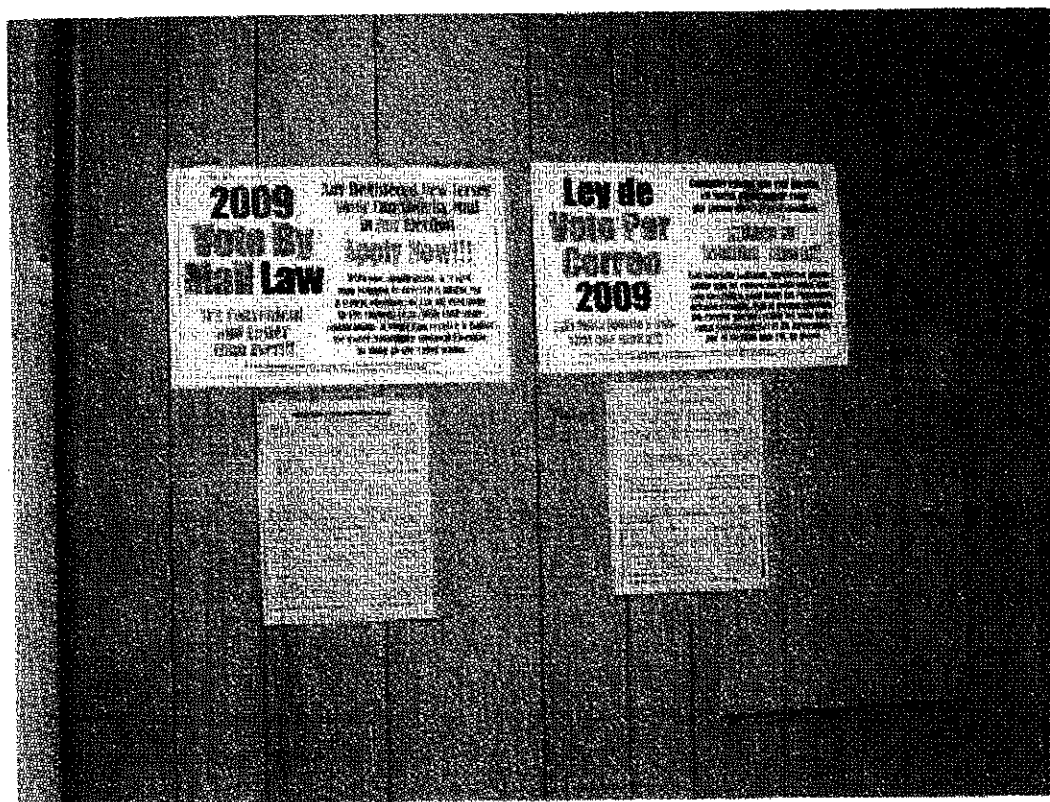
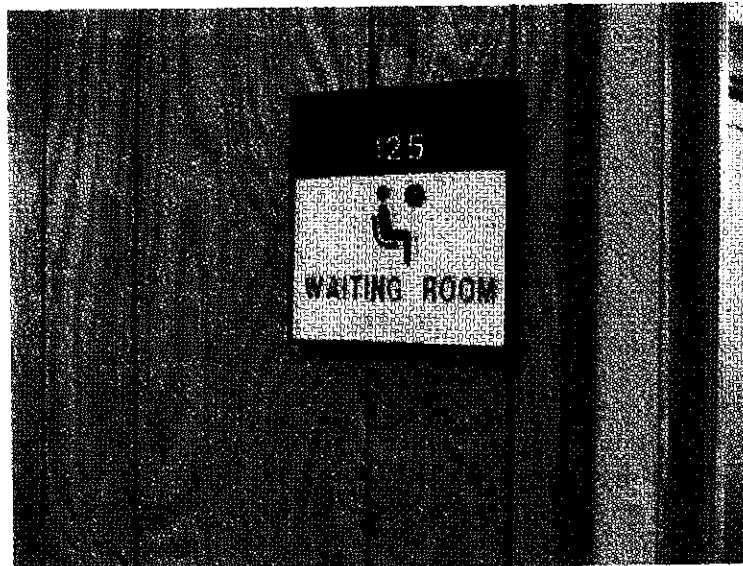
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The following table shows the number of persons who have been convicted of crimes in the State of New York, from 1880 to 1890, and the number of persons who have been sentenced to the State Prison, from 1880 to 1890, by the State of New York.

Year	Persons convicted of crimes	Persons sentenced to the State Prison
1880	1,234	1,234
1881	1,345	1,345
1882	1,456	1,456
1883	1,567	1,567
1884	1,678	1,678
1885	1,789	1,789
1886	1,890	1,890
1887	1,901	1,901
1888	1,912	1,912
1889	1,923	1,923
1890	1,934	1,934

2016年12月31日
 2017年1月1日
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 2018年1月1日

Admissions Unit/Waiting Room



11

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1990

THE UNIVERSITY OF CHICAGO

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DO I DO HAVE A COMPANY WITH ONE EMPLOYEE?

1997-1998

1. *What were the three most important factors that influenced the development of the American West?*

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It is not possible to discuss such a significant field in connection with a special issue devoted to the topic of "new" materials, even though this is a particularly relevant area of research. The authors of the review have tried to make this review as useful as possible for researchers working in this field.

1. **Introduction**
 2. **Background**
 3. **Methodology**
 4. **Results**
 5. **Discussion**
 6. **Conclusion**
 7. **References**
 8. **Appendix**
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...and the client

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1. The first step in the process is to identify the problem or issue that needs to be addressed. This involves gathering information and understanding the context of the problem.

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1. *Phragmites australis* (Cav.) Trin. ex Steud.

It is important to note that the results of this study are based on a cross-sectional design, which limits the ability to establish causality. Future research should employ longitudinal designs to investigate the temporal relationships between the variables studied.

1. The first step in the process of the development of a new product is the identification of a market need. This is done by conducting market research and analyzing the needs of potential customers. The next step is to develop a concept for the product, which involves creating a detailed description of the product's features and benefits. This is followed by the development of a prototype, which is a physical model of the product that can be used to test its functionality and design. The final step is the production of the product, which involves manufacturing the product in large quantities and distributing it to the market.

1. The first step in the process of identifying a problem is to determine the nature of the problem. This involves gathering information about the problem and its causes.

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1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.

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For the first time, the proposed funding for the program will be \$100 million, up from \$75 million in the previous program. The program will be managed by the Department of the Interior, Bureau of Land Management, and the Department of the Interior, Bureau of Reclamation. The program will be managed by the Department of the Interior, Bureau of Land Management, and the Department of the Interior, Bureau of Reclamation.

DO YOU HAVE A COMPLAINT OR GRIEVANCE?

PATIENT COMPLAINT AND GRIEVANCE PROCEDURE

All staff at Ancora Psychiatric Hospital are expected to serve as advocates for patients' welfare. If patients or family members believe their rights have been violated, or they wish to express concerns/complaints about their aspects of care, they may do so in the following ways/manner:

- Through Life Management Meetings, which are held on each unit to address complaints, resolve conflicts, announce upcoming events, schedule changes and elicit suggestions and opinions of patients on a variety of issues pertaining to the unit community.
- Through patient delegates who are selected to attend monthly Client Council meetings as a forum for patient's hospital-wide.
- In a meeting with a member of the Treatment Team or Program Coordinator/Team Leader.
- In a meeting with the Unit Administrator/Section Chief.
- In a meeting with the Patient Advocate/Client Services Representative, who is located on the hospital grounds, and may be reached at 800-613-3516.
- By filing a formal grievance using the Patient/Family Grievance Form. (See details on the hospital's grievance process posted on the unit and in the visitors' room or see your Program Coordinator/Team Leader.)

In the event that a patient or family member is not satisfied with the response, he/she may contact any of the following:

If you have concerns regarding your medication, you may talk to the Medication Advocate or "Rennie Advocate": Mr. Anthony Haynes1-800-613-3516

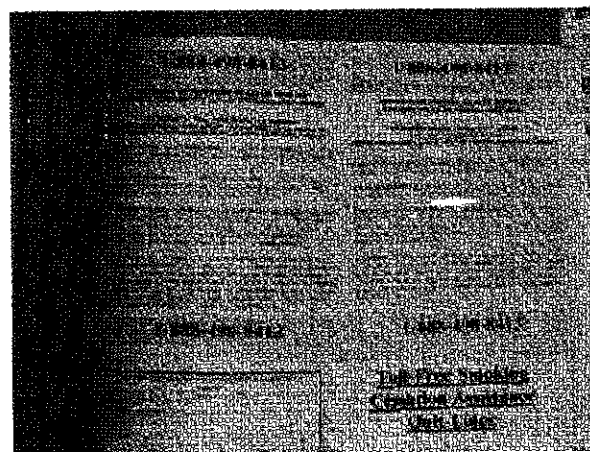
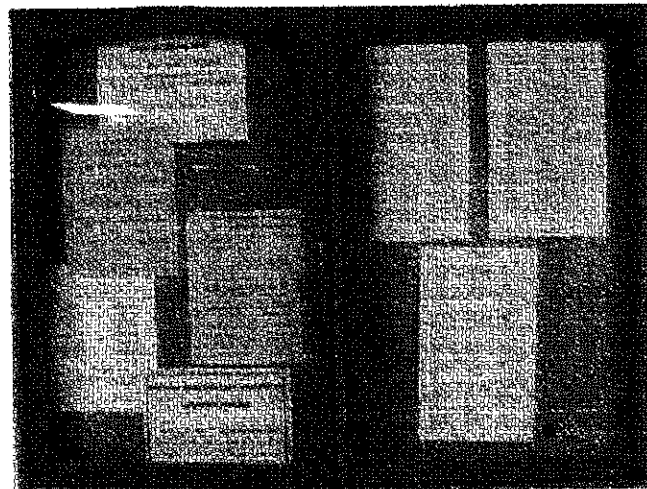
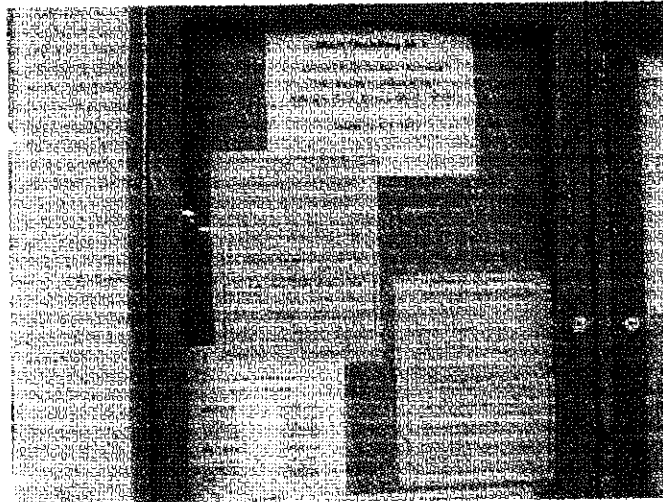
For problems of a general nature, you may talk to the Client Services Representative or "Patient Advocate": Ms. Diane McKenzie1-800-613-3516

In the event that a patient or family member is not satisfied with the response he/she may contact any of the following:

- Patient Services Compliance Unit, DMHS:.....1-888-490-8413
- New Jersey Protection & Advocacy, Inc.:.....1-800-922-7233
- Division of Mental Health Services Information & Complaints:
.....1-800-382-6717
- Public Defender:.....1-609-292-1750
- Ombudsman for the Elderly Hotline:.....1-877-582-6995
- New Jersey Alliance for the Mentally Ill: (Local Chapters):.....1-732-940-0991
- Federal Office of Civil Rights:.....1-212-264-3313
- The Joint Commission:.....1-800-994-6610
or(e-mail: complaint@jointcommission.org)

Drug Hotline — 4299

M 3 Bulletin Boards



have offered improved programs and materials. Some showed an explicit commitment to support the use of computers and materials science. Many have had outstanding faculty. This section will be published.

For further information, see "Changes Needed for Level of Understanding" Table (next).

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1. *Quantitative analysis of the data is not possible because the data are not quantitative.*

It is not possible to make a general statement about the impact of the 1990s on the world economy. The impact has been different in different regions and for different countries. In some regions, the 1990s have been a period of rapid growth and development, while in others, it has been a period of stagnation and decline. The impact has also been different for different groups of people. In some countries, the 1990s have been a period of rapid growth and development, while in others, it has been a period of stagnation and decline. The impact has also been different for different groups of people. In some countries, the 1990s have been a period of rapid growth and development, while in others, it has been a period of stagnation and decline. The impact has also been different for different groups of people.

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Consider aspects of a collection that are relevant to the future of the
 collection (the *horizon*).
 • Consider the *value* attached to the collection and how it
 should be managed accordingly, particularly the *value* to the
 public. Consider *value* as a *process* (not a *product*).

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1. The first step is to identify the problem or question that needs to be addressed. This involves understanding the context and the specific requirements of the task.

For the purpose of this study, the following definitions were used:

1. The first step in the process of creating a new product is to identify a market need. This involves conducting market research to determine what consumers want and what problems they are trying to solve. Once a need is identified, the next step is to develop a concept that addresses that need. This is often done through brainstorming sessions with a team of designers and engineers. The concept is then refined through prototyping and testing, with feedback from potential users being used to make improvements. Finally, the product is manufactured and distributed to the market. Throughout this process, it is important to maintain a focus on the user's needs and to iterate on the design as much as possible to ensure that the final product is both useful and desirable.

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Abstract—The purpose of this study was to determine the effect of a 12-week training program on the heart rate (HR) and heart rate reserve (HRR) of sedentary, middle-aged men. The subjects were divided into two groups: a control group and an exercise group. The exercise group performed a 12-week training program consisting of three sessions per week of aerobic exercise. The control group did not exercise. The HR and HRR were measured at rest and during maximal exercise at the beginning and end of the 12-week period. The results showed that the exercise group had a significant decrease in HR and HRR at rest and during maximal exercise compared to the control group. The control group had no significant change in HR and HRR. The results suggest that a 12-week training program can improve the cardiovascular fitness of sedentary, middle-aged men.

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[illegible][illegible]

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El nombre:: **Anthony Haynes** **1-800-613-3516**

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La Oficina Federal de Derechos Civiles 212-264-3313

EXHIBIT Y

1 UNITED STATES DISTRICT COURT
 2 FOR THE DISTRICT OF NEW JERSEY
 3 CIVIL ACTION NO.: 2:10-cv-03950

4 DISABILITY RIGHTS NEW)
 JERSEY, a New Jersey)
 5 Non-Profit Organization,)

6 Plaintiff,)

7 vs.)

DEPOSITION UPON
 ORAL EXAMINATION
 OF
 RACHEL M. PARSIO

8 JENNIFER VELEZ, in her)
 official capacity as)
 9 Commissioner, State of)
 New Jersey Department of)
 Human Services,)

10 Defendant.)

11 Tuesday February 21, 2012

12 T R A N S C R I P T of the deposition of
 13 RACHEL M. PARSIO called for Oral Examination in the
 14 above entitled action, said deposition being taken
 15 pursuant to Rules governing Federal Procedure in the
 16 State of New Jersey, by and before JEAN E. DOLAN,
 17 License No. 809, a Notary Public and Certified Court
 18 Reporter of the State of New Jersey, at the HOAGLAND,
 19 LONGO, MORAN, DUNST & DOUKAS, LLP, 40 Bayard Street,
 20 New Brunswick, New Jersey, commencing at 10:15 in the
 21 forenoon.
 22

23 JEAN E. DOLAN ASSOCIATES
 Certified Court Reporters
 3 Parlin Drive
 24 Parlin, New Jersey 08859
 (732) 238-7666
 25 Fax (732) 613-4666

 ORIGINAL

1 Q In the -- under Essential Duties and
2 Responsibilities, the first bullet point, there's an
3 indication that you interview clients, identify
4 client concerns. You see that on the document?

5 A Right, yes.

6 Q Does that entail interviewing patients
7 in the state hospitals currently?

8 A Yes.

9 Q And address -- identifying and/or
10 addressing their concerns?

11 A Yes.

12 Q And do you consider Disability Rights
13 New Jersey to be a, quote unquote, independent
14 watchdog over the state hospitals in that regard?

15 MS. KOLOD: I object to form.

16 A Is it okay if I don't use your term as a
17 watchdog? Is that okay?

18 Q Okay.

19 A We are -- we respond to the complaints
20 and if we see other system issues, we address those
21 also.

22 Q So if you identify a concern or
23 complaint, how do you address them?

24 A I bring the issue back to our
25 coordinator.

1 you go there when there are patients milling about
2 and indicate where you're from, who you are, does
3 anyone want to speak to you, anything of that nature?

4 A Yes.

5 Q You do do that?

6 A Yes.

7 Q What do you say to the patients that you
8 see?

9 A To the patients? That I would ask them
10 -- a lot of them know me, so they will come up to me.
11 I would ask them if they have any issues that we
12 could provide assistance to them. I will take that
13 information back to the agency and provide it to the
14 intake department.

15 Q Will you indicate when you arrived who
16 you are, where you're from?

17 A Yes.

18 Q Indicate does anyone want to speak with
19 me, something to that effect?

20 A Yes.

21 Q And if you go on a weekly basis, do you
22 generally make that announcement on a weekly basis
23 when you arrive?

24 A Yes.

25 Q You indicated that patients know you or

1 know who you are?

2 A I have been assigned there for so many
3 years a lot of the patients do know who I am and will
4 come up to me.

5 Q Okay. And do they also know how to
6 contact the Disability Rights New Jersey by phone?

7 A Yes.

8 Q Are there postings throughout the
9 hospital that indicate the Disability Rights New
10 Jersey phone number, for instance?

11 A Yes.

12 Q Are they posted throughout the hospital
13 at various locations on bulletin boards?

14 A Yes.

15 MR. CHABAREK: I'm going to mark this as
16 Exhibit D 13.

17 (D 13 marked for identification.)

18 Q Just take a look at the document which
19 we identified as D 13.

20 A Okay.

21 Q Okay. Ms. Parsio, have you seen a
22 posting in that regard on the bulletin board at
23 Ancora as reflected in Exhibit D 13?

24 A Yes.

25 Q And there's a number of phone numbers

1 indicated at the bottom, and included there is
2 the -- the Rennie Advocate or Anthony Haynes. You
3 see that?

4 A Yes.

5 Q It's an 800 number. Do you know who
6 Anthony Haynes is?

7 A Yes.

8 Q And on the bottom it indicates: "If you
9 are still not satisfied after attempting to resolve
10 your problems at the hospital level, you may also
11 call the following", and there are a number of phone
12 numbers identified there?

13 A Yes.

14 Q And included in there is the New Jersey
15 Protection Advocacy?

16 A Yes.

17 Q With an 800 number?

18 A Yes.

19 Q And you see a posting in that regard or
20 similar to that at Ancora on the bulletin board?

21 A Yes. But it may not be on every
22 bulletin board. You know, I haven't checked every
23 bulletin board but definitely, yes.

24 MR. CHABAREK: I'm going to mark Exhibit
25 D 14, which is the actual posting.

1 A He's the Rennie Advocate.

2 Q Do you know what his job function is?

3 A Yes.

4 Q What is his job function?

5 A Parts of his job. I don't know
6 everything that he does.

7 Q Part of it.

8 A I know that he reviews the patients that
9 are refusing and non-refusing status on a monthly
10 basis.

11 Q Okay.

12 A And prepares the reports for the
13 administration of the hospital. He also meets with
14 patients as part of the three-step process to discuss
15 their issues with medications. Also handles the
16 voting process to make sure that patients are aware
17 of how to vote if they want to and handles that.
18 That can change.

19 Q Okay.

20 A I'm not sure of any other procedures
21 that he would do.

22 Q Is he visible throughout the hospital?

23 A Yes.

24 Q Patients know who he is?

25 A Yes. Most of the time I would say they

1 remember this statement. We may have discussed it
2 but I don't remember how it came about. You had said
3 did he -- did he say this on his own or did we have a
4 conversation with him about this.

5 Q Yes. My question was did he tell you
6 that spontaneously on his own without any prompting?

7 A I can't remember. I can't remember
8 exactly how it came about.

9 Q In the mental health field you always
10 worked in the State of New Jersey. Correct?

11 A Yes.

12 Q You never worked in any other states?

13 A No.

14 Q Okay. So you understand the state of
15 law in New Jersey does not require that there be
16 judicial hearings before medication be involved or
17 administered currently. Correct?

18 A Correct.

19 Q Do you have any experience with such
20 judicial hearings in other states?

21 A Only that I do know that other states do
22 have that process.

23 Q Other than knowing that, do you
24 know -- have you ever had any experience dealing with
25 that process from other states?

1 A No.

2 Q In paragraph 29 it states: "I am aware
3 that the Disability Rights New Jersey may file a
4 lawsuit regarding involuntary administration
5 psychotropic medication in New Jersey hospitals. I
6 make this certification in support of DRNJ's lawsuit.
7 I am aware that I may be called upon to testify in
8 connection with the DRNJ's lawsuit and am willing to
9 do so."

10 You see that statement?

11 A Yes.

12 Q Is there anywhere in that statement
13 where the patient certifies that the statements he
14 set forth are true? Is there anything in that
15 paragraph where he indicates that?

16 A In this paragraph you're saying is there
17 anything that --

18 Q Is there any language in that paragraph
19 where the patient attests to the truth of the
20 statements contained throughout?

21 A I'm sorry. I don't understand the
22 question.

23 Q Does that paragraph contain any language
24 wherein PD represents that everything he stated was
25 true?

1 Q Do you have any knowledge if another
2 advocate from the Disability Rights New Jersey ever
3 met with this patient WF to compile this information?

4 A Not that I know of. There might have
5 been -- I know at one point we had interns doing some
6 work in Ancora, but I do not remember this.

7 Q Do you remember the names of those
8 interns who were doing --

9 A No.

10 Q Let me finish the question. Do you
11 remember the names of those interns who were going to
12 Ancora?

13 A No.

14 Q Was their purpose to secure information
15 as well?

16 MS. KOLOD: Objection to form.

17 Q As contained in the certification?

18 A Yes.

19 Q Also, as you sit here today you have no
20 recollection of patient WF or the contents of the
21 certification and don't -- you never met with this
22 patient?

23 A I don't remember.

24 MR. CHABAREK: Okay. I'm going to have
25 marked as Exhibit D 18, a Certification in Support of

1 Q Do you know an individual by the name of
2 Lorraine Ghormley?

3 A Yes.

4 Q And who is she?

5 A She's an attorney or she was, I'm sure
6 she's -- I'm not sure if she's still there with the
7 public advocate's office.

8 Q Are you aware of an incident she had
9 been involved in while at Ancora Psychiatric Hospital
10 while meeting with a patient?

11 A Yes.

12 Q What are you aware of?

13 A I'm aware that she was interviewing a
14 patient and I don't know who the patient was but I'm
15 aware she was interviewing a patient. She asked the
16 patient a question and during the interim of her
17 interview the patient knocked her to the floor and
18 assaulted her.

19 Q Were you present at the facility when
20 this occurred?

21 A No.

22 Q How did you learn of it?

23 A She told me.

24 Q Ms. Ghormley told you?

25 A Yes.

1 Q Have you ever felt threatened by a
2 patient in your career?

3 MS. KOLOD: Objection to form.

4 A No.

5 Q So never in -- going on almost 20 years
6 you never felt threatened?

7 A There have been times when I've been
8 cautious, but I never felt threatened -- actually,
9 the patients would try to protect me at certain
10 times. If someone would come up to me and say they
11 wanted to talk to me, they would say I'm talking to
12 her now, you know, leave us alone. I've never felt
13 threatened.

14 Q And that would be for both in your
15 capacity at both employers, whether it be Disability
16 Rights New Jersey, DRNJ, or the prior employer?

17 A You mean --

18 Q The New Jersey Alliance?

19 A No, never felt threatened.

20 Q Are you aware what the standard is for a
21 patient to be involuntarily committed to the state
22 psychiatric hospitals?

23 A Yes.

24 Q What is it in your mind is the standard?

25 A They have to be judged as a danger to

1 A Yes.

2 Q What his role is?

3 A Yes.

4 Q Would it be fair to say that you're both
5 quite active in bringing patient concerns to people
6 at the hospital?

7 MS. KOLOD: Objection to form.

8 A Yes.

9 Q And do you work with Anthony Haynes at
10 times, do you work in conjunction with him to address
11 concerns?

12 A Yes.

13 Q You have a good working relationship
14 with him?

15 MS. KOLOD: Objection to form.

16 A I would say a very good working
17 relationship with him. I usually meet with him
18 several times a month when I go there.

19 Q Is it your understanding that he deals
20 with patient complaints that are geared towards
21 medication related issues?

22 A Yes.

23 Q Earlier when we talked about patient SD
24 who there was an allegation from the mother who
25 contacted you that he almost died as a result of some

1 Q We previously spoke about you have a
2 working or your working relationship with Anthony
3 Haynes?

4 A Yes.

5 Q And you mentioned his role, you
6 mentioned your role. Do your duties in some way
7 overlap?

8 MS. KOLOD: Objection to form.

9 Q In other words, does your role and his
10 role towards the patient overlap in some case in
11 terms of medication?

12 MS. KOLOD: Yes.

13 A Yes, somewhat.

14 Q And you meet with him frequently, as you
15 indicated, to address patient concerns?

16 A Yes.

17 Q Okay. I'm just going to show you what
18 was previously provided Bates stamped DRNJ M-00685
19 through 688, which is a fax addressed to Ms. Parsio
20 from Anthony Haynes dated May 9, 2001.

21 (D 20 marked for identification.)

22 Q I'm going to provide to you what's
23 marked as Exhibit 20, and I ask you to take a look at
24 the document. It's a four-page document.

25 Have you ever seen that document before

1 keep up on medications.

2 Q But you wouldn't profess to have an
3 expertise in what type of medications to be
4 administered or doses or anything like that?

5 A No.

6 Q That's up to the clinician or the
7 physician?

8 A Yes.

9 Q What knowledge do you have with respect
10 to psychotropic medications? For instance, side
11 effects, do you read journals? What do you do to
12 learn about that?

13 A I read, I go to certain workshops. I
14 know several of the antipsychotic drugs and
15 psychotropic drugs and also am aware of tardive
16 dyskinesia and akinesia. That's the way you
17 pronounce that. They are forms of side effects from
18 psychotropic drugs.

19 Q What knowledge do you have about those
20 side effects?

21 A That they can be life threatening.

22 Q Okay.

23 A That they -- a certain antipsychotic
24 like Flurazine and Haldol if used over a long period
25 of time they can create side effects as rigidity

1 where you can't swallow, and I've even experienced
2 seeing a patient that couldn't swallow, shuffling of
3 feet, not being able to stand in one place, drooling
4 of the mouth, really very very serious side effects.
5 It would be life debilitating. I've done a lot of
6 reading and research. I've also attended a lot of
7 research conferences in Washington when I would go to
8 the conferences for the New Jersey Alliance For the
9 Mentally Ill.

10 Q And but you wouldn't profess to be an
11 expert on side effects. That's up to the clinicians.
12 Correct?

13 A Yes.

14 Q If a patient tells you they are having a
15 specific side effect, do you know anything to verify
16 that side effect or do you take them at their word?

17 MS. KOLOD: Objection to form.

18 A You can observe it at times from my one
19 case. He was drooling at the mouth. He couldn't
20 even raise his head. Tried to speak to me. He could
21 not even raise his head up off the chair. He was
22 taken to the chair by two aides. He couldn't walk.
23 He was wetting himself. And another staff member
24 told me in the elevator that she was very concerned
25 about him because she thought that they were

1 Q And you would have conveyed that to her
2 prior to when you had a discussion with her about her
3 deposition?

4 A No. It was a long time ago.

5 Q You recall having that specific
6 conversation with her about her deposition about
7 looking at the website or pulling out documents?

8 A No, no, no.

9 Q And when we looked at the postings on
10 the bulletin board before we talked about the fact
11 that the Rennie Advocate is identified, the
12 Disability Rights New Jersey is identified. Correct?

13 A Yes.

14 Q You indicated that Anthony Haynes is
15 visible throughout the hospital?

16 A Yes.

17 Q Throughout the Ancora Psychiatric
18 Hospital?

19 A Yes.

20 Q So that the patient knows who the Rennie
21 Advocate is?

22 A I don't know if all the patients know,
23 but some of them know. I'll often say to them if you
24 have a medication issue, did you discuss this with
25 Anthony.

EXHIBIT Z

1 the years -- and I don't mean that in the
2 derogatory fashion because I couldn't because I'm
3 sitting here with too many years behind me -- but
4 has it been your experience over the years that
5 medications when properly utilized can effect an
6 improvement in the disease process in an
7 individual patient?

8 A. When properly utilized, yes.

9 Q. And indeed medications can play a
10 major role in enabling, ultimately, an individual
11 to get better to the point where they can return
12 in some fashion to society and be gainfully
13 employed and having a much happier life; fair
14 enough?

15 MS. WELLS: Objection to the
16 form.

17 A. I wouldn't say a major role. I
18 would say --

19 Q. Okay. Is there something out
20 there, some treatment modality that you would say
21 has the major role in enabling patients to leave
22 an inpatient setting and be successful in the
23 community?

24 A. No. I think there's a variety of
25 modalities.

1 them down.

2 Q. And what evidence do you have for
3 that?

4 A. Patients have reported that to me.

5 Q. Okay. Patients take them down?

6 A. Staff will say that the patients
7 have taken them down, and then --

8 Q. Okay. But you haven't -- first of
9 all, there's the mechanism of rather prominent
10 announcements or information on bulletin boards at
11 the hospital saying DRNJ, whatever it says, that's
12 a mechanism that you know that patients use to get
13 in touch with you; right?

14 A. Right.

15 Q. Okay. And then there is also the
16 fact that you are in the institutions on a regular
17 basis?

18 A. Yes.

19 Q. And how frequently are you -- you
20 said -- I should ask you this: You mentioned that
21 TPH and Hagedorn are your primary institutions.
22 Are they still your primary institutions?

23 A. Yes.

24 Q. So how is your schedule put
25 together?

1 Q. And here is a closeup of the
2 plaque, and on the back of this, D-3, is also
3 another bulletin board. These are all from TPH?

4 A. Yes.

5 Q. And here is a blowup of the
6 plaque. What does that plaque tell patients
7 about?

8 A. It tells patients that the patient
9 advocate is for general complaints and grievances
10 and gives their tollfree number. And then it
11 gives a patient advocate for medication complaints
12 and grievances and also gives a tollfree number.

13 Q. Okay. And indeed, on the bulletin
14 board are you aware that there are other notices
15 that are posted about the ability of patients to
16 contact an advocate with respect to medications?

17 A. I think there are -- yes. I think
18 they have some kind of indication on there that
19 there's, there may be a ready advocate available
20 to them.

21 Q. And for the purposes of the
22 record, the Rennie advocate is the individual who
23 is assigned as a client service rep, but he or she
24 specifically deals with complaints having to do
25 with medication dosing, involuntarily medicating

1 different things.

2 Q. Okay. So when you are given
3 copies of patient charts or portions of patient
4 charts, do you sometimes take them from the
5 facility to Trenton or even perhaps home to work
6 on?

7 A. No. I don't -- our protocol is
8 that if we want to request copies of records, we
9 send out requests through the head of the
10 hospital, the chief executive officer, who in turn
11 disseminates that request to whomever to respond
12 and provide either a response and/or the records
13 that have been requested.

14 Q. Okay. But my question was when
15 you get the records, I presume they are given to
16 you at the facility?

17 A. No. They come by courier.

18 Q. Okay. They come by courier to the
19 main office in Trenton?

20 A. Yes.

21 Q. And then you have them there to
22 review and prepare whatever you're going to
23 prepare based upon those records?

24 A. Yes.

25 Q. Okay. And if you find that you've

1 their medication issues?

2 A. From time to time, yes.

3 Q. Okay. That may indeed, that
4 activity may indeed overlap with your activities;
5 right?

6 MS. WELLS: Objection to the
7 form.

8 A. At times, yes.

9 Q. In other words, a patient may have
10 a complaint -- I'll do it this way: Have you seen
11 instances where patients have complaints that are
12 medication-related and they've not only gotten a
13 hold of you but they've gotten a hold of the
14 Rennie advocate?

15 A. Yes. As a general rule I will ask
16 patients as a general issue have you talked with
17 the Rennie advocate about this.

18 Q. And they will either answer you
19 No, I haven't or Yes, I have, because your
20 authority is wholly separate from the Rennie
21 advocate; right?

22 A. Yes.

23 Q. Okay. What I've just handed you,
24 D-1, -2 and -3, I guess, the Rennie advocates and
25 their numbers, how patients contact them, pretty

1 much have the same currency, that is they're on
2 the billboard just like you are; right?

3 A. Yes.

4 Q. And indeed, they have an extra
5 thing because you're looking at the plaque, at
6 least at TPH there's a big old plaque right above
7 the phone; right?

8 A. Uh-huh.

9 Q. And if you look at the phone, you
10 can't miss seeing the plaque, can you?

11 MS. WELLS: Objection to the
12 form.

13 A. If you're short you can. And if
14 your eyes aren't blurred you can read it also.

15 Q. Okay. And if your eyes aren't
16 blurred or you're too short or you're too tall you
17 can read the DRNJ paper; is that correct?

18 A. Yes.

19 Q. It's also true, is it not, that
20 upon admission patients to TPH and Hagedorn -- I'm
21 staying with the hospitals that you're most
22 familiar with -- that they are given a number of
23 written materials including a handbook or a
24 guidebook, whatever you want to call it, that
25 lists you or lists your services to DRNJ and lists

1 the Rennie advocate; right?

2 A. Yes.

3 Q. Have you seen instances or
4 experienced instances where patients will contact
5 you because they read about you in the guidebook?

6 A. I don't recall any instances where
7 they have gotten our number from the guidebook.
8 Generally they disappear shortly after their
9 admission.

10 Q. What do you mean, "they
11 disappear"?

12 A. They disappear. Either clients
13 throw them away, staff throw them away. I have
14 asked clients don't you have your information that
15 you received on admission, and it doesn't exist.

16 Q. Okay. Which makes --

17 A. Unfortunately.

18 Q. -- it frustrating for you, I
19 assume, here or there; right?

20 A. Absolutely.

21 Q. Okay. Now, as part of your duties
22 as an advocate for DRNJ, are there circumstances
23 where you feel it would be acceptable to lie to
24 the staff or administration of a hospital?

25 A. Where --

1 A. Only some of them.

2 Q. Okay. So, however, you are
3 certainly familiar that a number of these
4 certifications were prepared; right?

5 A. Yes.

6 Q. Was the effort here to obtain
7 information from patients and put it into some
8 kind of a format which you see in front of you to
9 be possibly used in litigation?

10 MS. WELLS: I just want to
11 caution Ms. Spensley not to reveal any legal
12 advice that she sought or received from counsel,
13 either internal or external.

14 But if you can answer that question
15 otherwise, please do.

16 A. Please ask the question again.

17 Q. I forgot it. I think.

18 (Pending question was read by the
19 Reporter.)

20 A. Yes.

21 Q. Okay. Indeed, the effort here, I
22 assume, was to get the statements from patients in
23 order for them to be used in some way in this
24 litigation that had the pleasurable side effect of
25 you and I meeting?

1 complaints or statements as part of your function
2 with DRNJ, irrespective of any litigation;
3 correct?

4 A. That's correct.

5 Q. But then there came a time when
6 you went to patients not just for the purpose of
7 checking in on them and obtaining the usual data
8 you wanted for your job, but that you were to
9 obtain some kind of information that might be
10 useful in litigation; correct?

11 MS. WELLS: Objection to the
12 form.

13 Go ahead.

14 Q. And let me make sure. You look --
15 the witness looks befuddled, and I don't blame
16 her.

17 Part of your job is to go around
18 and sit with patients as their advocate and take
19 information that is pertinent to your job
20 function; is that correct?

21 A. Yes.

22 Q. And at some point, however, you
23 went and sat down with patients, not just for that
24 purpose but also as you understood it to get
25 certain kinds of information in connection with

1 illness other than medication.

2 Q. Okay. Are there people who you've
3 encountered in the hospitals that are prone to
4 violence?

5 MS. WELLS: Objection to the
6 form.

7 A. There are, yes, there are.

8 Q. Okay. There are people that you
9 have not particularly wanted to see or have been
10 able to see at particular points in time because
11 they are at that time prone to violence or
12 aggression or assault or have threatened that;
13 correct?

14 MS. WELLS: Objection to the
15 form.

16 A. No. That's not correct.

17 Q. Okay. What do you envision the
18 hospital doing with a patient who is assaultive,
19 who is threatening to kill another patient while
20 they are waiting for the judge?

21 MS. WELLS: Objection to the
22 form.

23 A. Hospitals do have emergency
24 procedures where they can thereby medicate a
25 person under certain criteria for a 72-hour

1 period.

2 Q. All right. And if it takes longer
3 than 72 hours for informed counsel to get
4 involved -- after all, they have to review
5 everything -- and for a judicial hearing to be
6 scheduled for that particular patient, do we do
7 another 72-hour certificate if that patient is
8 still showing signs of assaultive or violent
9 tendencies?

10 MS. WELLS: Objection to the
11 form.

12 A. In the current system I don't
13 believe they are actually allowed to do
14 back-to-back 72-hour certifications. They would
15 have to implement a three-step procedure.

16 Q. Okay. Well, in your scenario,
17 which you've told me about from your experience
18 and wisdom on the ground where we have a
19 judge-type procedure with counsel and all these
20 things, they can do one 72-hour procedure, but
21 what would happen in your system when the patient
22 is still assaultive and has violent tendencies and
23 is still, as in one instance that you may know
24 about, threatening to kill another patient who
25 happened to be pregnant?

1 MS. WELLS: Objection to the
2 form.

3 Q. What do we do now?

4 A. Hospitals put people on one-to-one
5 levels of supervision where they have an
6 individual staff person that goes right alongside
7 that person. They have historically,
8 unfortunately, also used seclusion restraints for
9 people. The medications have somewhat replaced
10 those as chemical restraints. And there are,
11 again, there are a variety of other interventions
12 that can be utilized other than giving someone
13 medication until it's been judicially authorized.

14 Q. Okay. So what you're saying is
15 under your system after the first 72 hours if the
16 patient is still displaying the same symptoms and
17 is assaultive and is violent or whatever, that you
18 would say Well, they could be put on one-on-one;
19 correct?

20 MS. WELLS: Objection to the
21 form.

22 A. Yes.

23 Q. Or under your system we would
24 restrain them physically?

25 MS. WELLS: Objection to the

1 form.

2 Q. Is that right?

3 A. That's an alternative available.

4 Q. Okay. Now, a patient in that
5 state, a patient who is verbally abusive, is
6 threatening people, is showing signs of
7 aggression, who is perhaps destroying property or
8 trying to destroy property or who is attempting to
9 hurt themselves, those people are suffering,
10 aren't they?

11 MS. WELLS: Objection.

12 A. That would be an opinion.

13 Q. Well, you know --

14 A. It's not my opinion.

15 Q. Well, now, wait a minute. People
16 with mental illnesses, these illnesses cause
17 suffering in these people, don't they?

18 MS. WELLS: Objection to the
19 form.

20 A. Depends on your definition of
21 "suffering," sir.

22 Q. Well, do you think from all your
23 experience in the years in the mental health field
24 that a person who is experiencing a mental
25 illness -- and maybe not all of them, but many of

1 MS. WELLS: Objection to the
2 form.

3 A. My experience, what I have been
4 told by patients and clients over the years is
5 their suffering is caused by the treatment
6 conditions and the drugs that they are forced to
7 take, not as much as their illness causes them
8 suffering. Their illness may cause their family
9 suffering, which is unfortunate.

10 However, my experience in my countless
11 hours of talking and being with and conversing
12 with individuals is what it is. I believe that
13 there's more suffering induced upon them than
14 their illness has already caused.

15 Q. So the last part of that was an
16 acceptance that the illness can cause suffering
17 standing on its own?

18 MS. WELLS: Objection to the
19 form.

20 A. Yes.

21 Q. Have you encountered at least one
22 patient in all these years that was suffering with
23 their illness, was given medication and got
24 better?

25 A. Yes, I have.

1 patients who are at the moment you encounter them
2 dangerous. They may be dangerous to themselves or
3 others, haven't you?

4 A. That have been categorized as
5 dangerous, yes.

6 Q. But whether they have been
7 categorized by somebody or not, you have met
8 patients who you felt at the time or assessed as
9 being at risk to harm themselves or others,
10 haven't you?

11 A. Very rarely, actually.

12 Q. Okay. All right. Have you
13 encountered patients that you felt uncomfortable
14 being with because you were afraid for your own
15 safety?

16 A. I can honestly say, telling the
17 truth, probably a couple of times in my entire
18 career where I felt threatened by any patient.

19 Q. Okay. Are you aware, however, as
20 a general matter from your readings and from your
21 conferences you go to, talking with other people
22 in the field, that there are patients out there
23 who are, who have a capacity to do harm to others,
24 unfortunately because of their illness? You're
25 aware of that; right?

1 MS. WELLS: That's all I have.

2 REDIRECT EXAMINATION BY MR. LEYHANE:

3 Q. So in other words, to the extent
4 they need it, the patients would have available
5 legal counsel through you and DRNJ; correct?

6 MS. WELLS: Objection to the
7 form.

8 Q. Based on what you just told us;
9 right?

10 A. They would have, yes, they would
11 have available that entity at some point.

12 Q. Sure. Okay.

13 MR. LEYHANE: That's all I have;
14 again, thank you for your patience.

15 -----

16 (Witness excused.)

17 (Whereupon at 5:24 PM the
18 deposition proceedings were concluded.)

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